

TOWN OF ISLIP
THERAPEUTIC RECREATION PROGRAM
DANCE APPLICATION

APPLICANT'S NAME: _____ AGE: _____ DATE OF BIRTH: _____

HAS THE APPLICANT PREVIOUSLY ATTENDED ONE OF OUR PROGRAMS? _____

ADDRESS: _____ TOWN: _____ ZIP: _____

TELEPHONE # _____ SEX: MALE _____ FEMALE _____

GRADE: _____ SCHOOL: _____

IF GRADUATED/EMPLOYED, PLEASE DESCRIBE: _____

PLEASE DESCRIBE ANY LEARNING, VISUAL, HEARING, SPEECH, PHYSICAL, COGNITIVE,
EMOTIONAL or OTHER DISABILITY THE APPLICANT HAS: _____

PLEASE DESCRIBE ANY PHYSICAL LIMITATIONS THE APPLICANT HAS: _____

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY?

NAME: _____ TELEPHONE #: _____

ADDRESS: _____ TOWN: _____ ZIP: _____

RELATIONSHIP TO APPLICANT: _____

IS THE APPLICANT ABLE TO TAKE PART IN GROUP ACTIVITIES WITHOUT SPECIAL
SUPERVISION? _____ IF NO, PLEASE EXPLAIN: _____

IS THE APPLICANT TOILET TRAINED? _____ IF NO, DESCRIBE HOW THIS WILL NOT INTERFERE
WITH THE ACTIVITY IN WHICH THE APPLICANT DESIRES TO PARTICIPATE: _____

NAME OF PERSON FILLING OUT THIS APPLICATION: _____

RELATIONSHIP TO THE APPLICANT: _____ TODAY'S DATE: _____